STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 focused survey was conducted 8/14/20 through 8/24/20. The facility was found in compliance with CFR 483.73 related to E-0024 (b) (6); Subpart B; Regulations for Long Term Care Facilities. Event ID: W10011.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted 8/14/20 through 8/24/20. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID -W10011	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		9/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/18/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 2 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of the facility ' s "COVID-19 Response Plan" the facility failed to implement the COVID-19 response plan by allowing a staff member (Nursing Assistant #1) to wear a cloth face mask while working in the facility. This observation occurred on 1 of 2 nursing units observed. This failure occurred during a COVID-19 pandemic. Findings included: The facility ' s "COVID-19 Response Plan" with a review date of 5/6/20 stated in part, "use of PPE and isolation strategies: all staff will be required to wear a surgical / isolation mask at all times while in the facility". An observation on 8/14/20 at 10:25 am revealed Nursing Assistant (NA) #1 was wearing a cloth face mask while working in the facility. The Director of Nursing (DON) was present during this observation of NA #1 on 08/14/20 at 10:25 am. During an interview with the DON on 8/14/20 at 10:28 am she stated NA #1 should be wearing a surgical mask when working in the facility. An interview on 8/14/20 at 11:08 am with NA #1 revealed she had routinely been wearing her own cloth face mask when she worked at the facility	F 880	1)During the infection control survey, a nurse aide was found wearing a cloth mask, The cloth mask was immediately replaced with a surgical mask. 2)no other employee was identified with a cloth Mask. 3)The Staff Development Coordinator In-serviced the nurse aide on 8/14/20 on the importance of donning and doffing the appropriate PPE, and using and following the correct isolation precautions and infection control measures at all times in the facility. SDC completed a 100% in-service on 9/24/20 with Staff on the importance of donning and doffing the appropriate PPE, and following the correct isolation precautions and infection control measures at all times in the facility. PPE (specifically masks) will be available at the front door during the check-in process (temps and log filled out). No one will be allowed to leave the check-in table without the proper mask in place. PPE (specifically masks) will be available at the front door during the check-in process (temps and log filled out). No one will be allowed to leave the check-in table without the proper mask in place.	

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F 880	Continued From page 3 and was not aware until today that she was required to wear a surgical type mask. NA #1 added she had received training on COVID-19 and isolation precautions but was not aware she could not wear a cloth face mask. An interview was conducted on 8/14/20 at 11:20 am with the Administrator and DON. The DON stated she had addressed the issue of wearing a cloth face mask with NA #1. The Administrator stated he expected all staff to wear a surgical and / or N95 mask when in the facility.	F 880	4)The Unit Managers/ADON to audit PPE usage by staff on units twice daily times 4 weeks, twice weekly times 3 months, and twice monthly times 3 months. The results of the audit will be reviewed by QAPI monthly x 3.	